Sinai Health | 恆康中心 Wellness Centre

☐ **Psychogeriatric Service for Chinese Patients (65+)**

☐ **Caregivers intervention for patients identify as the above**

Please Fax to: (416) 291-8813 T: (416) 291-3883
3660 Midland Ave. Unit 103, Scarborough, ON, M1V 0B8

REFERRAL FORM FOR PHYSICIAN

Name of Referring M.D.:	**Physician's Billing no.:**
Address:	**Tel. no.** **Fax no.**

Patient's Information

Name:	**Gender: M / F**
Health Card no.:	**Language (Dialect):** ☐ Cantonese ☐ Mandarin ☐ English ☐ other dialect:
Date of Birth (YY/MM/DD): **Patient MUST be 65 years old or above**	**Marital Status:** ☐ Single ☐ Married/Common Law ☐ Divorced ☐ Separated ☐ Widowed
Address:	
Telephone no(s): **Primary** ☐ H / ☐ C : **Other** ☐ H / ☐ C :	**Contact Person for appointment:** ☐ Patient ☐ Family Member **Name:** **Relationship:** **Tel. no.:**
Email:	

Reason(s) for Referral (please check the box(es):

- ☐ Psychiatric Assessment
- ☐ Medication Consultation
- ☐ Diagnostic Clarification
- ☐ Supportive Counselling
- ☐ Psychotherapy
- ☐ Caregivers intervention Only

Brief Description of Present Mental Health Difficulties or Other Psycho-social Problems

☐ Major Depression Disorder (MDD) ☐ Adjustment issues ☐ Psychosis* ☐ General Anxiety Disorder (GAD) ☐ Bereavement ☐ Dementia with behavioural issues (BPSD)
☐ Other (Please describe):

Brief Medical History (incl. medical conditions, surgeries, hospitalization, etc.)

Brief Psychiatric History (if applicable, incl. hospitalization, medications, previous psychiatrists, etc.)

Current Medications and/or Treatment

Allergies

Immediate Risks or Concerns (e.g. aggression, self-harm, addiction)

WC-F3 revised 2022-01

***Psychotic Symptoms Checklist:** (please check all that applies)

□ Hallucinations (auditory, visual, tactile, olfactory & command)
□ Delusions (Grandeur, persecution, somatic, ideas of reference)
□ Disorganized speech or behaviour
□ Socially withdrawn
□ Other: (please specify) _____

Additional Information:

Criminal/Legal Issues Pending:	□ No	□ Yes _____
Chemical Dependency:	□ No	□ Yes _____
History of Self Harm:	□ No	□ Yes _____
History of Aggression:	□ No	□ Yes _____
Risk of Falls:	□ No	□ Yes _____

*The following documents must be attached with the referral.

□ **Current Lab result (within 6 months)**

- □ **Hematology:** CBC
- □ **General Chemistry:** ALT, BUN, A1C, Creatinine, eGFR, UREA, Calcium, Albumin
- □ **Immunoassay:** TSH, Vit. B12
- □ **Microbiology:** Urine Culture & Sensitivity
- □ **Urinalysis**
- □ **Therapeutic blood level monitoring (if applicable):** Epival, clozapine, lithium

□ **Neurologist Consultation report if available**

□ **Neuroimaging report if available (e.g. CT, MRI)**

□ **Current Medication Administration Record (MAR) (if applicable)**

□ **Summary of progress notes**

Signature of Referring M.D.: _____ **Date:** _____